New Patient Information sheet

PATIENT NAME _____ AGE _____ DOB _____ GENDER: M F

PARENT NAME (If Applicable) _____ Outside Benton/Washington YES NO TODAYS DATE:_____

ADDRESS _____
City State Zip

PRIMARY PHONE #: _____ (HOME/WORK/CELL) SECONDARY PHONE #: _____(HOME/WORK/CELL)

EMAIL ADDRESS: _____

REFERRING PROVIDER:_____ **PCP:**_____

INSURANCE NAME: _____ POLICY ID NUMBER: _____GROUP #:_____

POLICY HOLDER NAME:_____DOB:_____

What are the concerns for you that you would like the doctor to address? TMS Anxiety Depression RX Management Behavior Issues

Other concerns/goals:_____

Are there any other questions or concerns regarding your mental health that you would like addressed?

_____

Have you been hospitalized for psychiatric needs in the past 2 months? YES NO

If yes, when and where? _____Duration of stay:_____
Medical records will need to be provided, please contact the hospital to release records to us.

Are you seeking TMS treatment Major Depressive Disorder? YES NO
If you are not diagnosed with Major Depressive Disorder what is your diagnosis?_____

Are you interested in medication management services as well as TMS? YES NO

Are you transferring care from another provider? YES NO Provider Name:_____

Preferred Pharmacy: _____
Name Address Phone

If you must cancel your appointment, please do so greater than 48 hours before the appointment. Not doing so will result in a charge of $75 which will need to be paid before the consultation can be rescheduled.

For office use only:

Date of patient contact:_____

Date paperwork sent to pt:_____

Date received all pwk/ put on desk:_____

Date MD reviewed and returned:_____

Date consult Scheduled:_____

4700 S. Thompson, Ste. C-103
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NWA PSYCHIATRY MANA

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NEW PATIENT PACKET FOR TMS INTERESTS ONLY

NAME: _____ TODAY'S DATE: _____

PHONE NUMBER: _____ DATE OF BIRTH: _____

RACE: _____ SEX: _____

OTHER NAME YOU PREFER TO BE CALLED: _____

NAME OF PERSON COMPLETING FORM: _____

WHO REFERRED YOU TO OUR CLINIC: _____

MAY WE CONTACT THEM: _____ YES _____ NO

NAME OF PRIMARY CARE DOCTOR OR PSYCHIATRIST: _____

CLINIC: _____

MAY WE CONTACT THEM: _____ YES _____ NO

PRIMARY CONCERNS FOR CONSULTATION: _____

_____

_____

ARE YOU DIAGNOSED WITH MAJOR DEPRESSION?: _____ YES _____ NO

IF NO PLEASE LIST DIAGNOSIS: _____

IF YES HOW LONG: _____

EXAMPLES OF HOW THIS EFFECTS YOU DAILY (Work, school, social, family, sleep, mood etc.):

_____

_____

_____

WHAT ARE YOUR GOALS FOR TREATMENT: _____

_____

_____

WHICH OF THE FOLLOWING SYMPTOMS/CONCERNS HAVE YOU EXPERIENCED IN THE LAST 60 DAYS:

_____ Sad or depressed mood _____ Withdrawn from family or friends

_____ Loss of interest in activities or hobbies _____ Feelings of guilt or worthlessness

_____ Feeling hopeless about the future _____ Sleep disturbance _____Change in appetite

_____Low energy or fatigue _____Trouble focusing or concentrating _____Thoughts of hurting self

_____Thoughts of suicide _____Thoughts of hurting or killing others _____Irritability

_____Severe angry outbursts (verbal or physical) _____Worrying too much

_____Feeling or acting restless _____Muscle tension _____Panic or anxiety attacks

_____Fear of looking stupid or being embarrassed _____Fear of offending others

_____Any other fears or phobias _____Drastic mood swings _____Episodes of decreased need for sleep

_____Extreme hyperactivity _____Racing thoughts _____Talking so fast it's hard to understand

_____Overly happy or euphoric _____Overly confident

_____Thoughts, feelings or images that come into your mind when you do not want them to?

_____Habits you feel you must do even if you know it does not make sense (for example excessive cleaning, checking, repeating, counting, organizing or hoarding things)?

_____Hearing voices that other people cannot hear _____Odd thinking or beliefs

_____Seeing things other people cannot see _____Feeling paranoid _____Poor body image

_____Trying to lose weight even though you are not overweight

_____Intentionally throwing up after eating _____Easily loses temper _____Easily annoyed

_____Defiant _____Argues with authority figures _____Annoying others on purpose

_____Blaming others for your mistakes _____Resentful, spiteful or vindictive _____Lying

_____Stealing _____Destroying property _____Setting fires _____Skipping school

_____Hurting other people or animals _____Difficulty learning

_____Trouble understanding social cues _____ Difficulty making/keeping friends

_____Sensitive to sound, light, touch or smell

HAVE YOU EXPERIENCED A TRAUMATIC EVENT: _____ Sexual abuse _____ Physical abuse

_____ Near death experience _____ Other traumatic event: _____

_____

SOCIAL HISTORY:

WHO LIVES AT YOUR PRIMARY RESIDENCE: _____ Spouse/significant other _____ Children

_____ Parent _____Brother(s) _____ Sister(s) _____ Roommate _____ Grandparent

_____ Foster children _____ Other: _____

CURRENT EMPLOYER: _____

HOW LONG AT THIS JOB?: _____

HIGHEST EDUCATION COMPLETED: _____ Post graduate degree _____ Bachelor's degree

_____ Associate's degree _____ Technical school _____ High school graduate

_____ Last grade completed if did not graduate

ARE THERE ANY CURRENT LEGAL PROCEEDINGS INVOLVING YOU? _____ YES _____NO

IF YES, PLEASE EXPLAIN: _____

_____

PREGNANCY HISTORY:

WAS YOUR MOM'S PREGNANCY COMPLICATED IN ANY WAY, PLEASE EXPLAIN IF YES:

_____ YES _____NO _____

_____

_____

DEVELOPMENTAL HISTORY:

WERE THERE ANY PROBLEMS WITH YOUR EARLY CHILDHOOD DEVELOPMENTAL MILESTONES (SIT, WALK, TALK, TOILET TRAIN, ETC)?

_____ YES _____NO _____

_____

PAST MEDICAL HISTORY:

HAVE YOU EVER HAD? _____ Headaches _____Seizures _____ Allergies (seasonal) _____Diabetes _____ Thyroid condition _____Asthma _____ Other lung problems _____Cancer _____ Head injury/concussion _____ Hypertension _____ OTHER:_____

_____

HAVE YOU EVER HAD ANY SURGERIES? _____ YES _____NO If yes, please list surgeries and dates:

_____

_____

CURRENT MEDICATIONS

Name	Dosage	Frequency	When started

PAST MEDICATIONS USED TO TREAT DEPRESSION

(this information is important for the approval process)

Name	Dosage	When Started/Stopped	Reason for Stopping

BIOLOGICAL FEMALES ONLY:

WHAT FORM OF BIRTH CONTROL DO YOU USE?_____

ARE PERIODS REGULAR? _____ YES _____NO DATE OF LAST MENSTRUAL CYCLE ____ / ____ / _____

IS THERE ANY CHANGE IN SYMPTOM SEVERITY WITH PERIODS? _____ YES _____NO

IF YES, PLEASE DESCRIBE_____

ARE YOU PREGNANT? _____ YES _____NO ARE YOU BREASTFEEDING? _____ YES _____NO

PAST PSYCHIATRIC HISTORY:

HAVE YOU EVER SEEN A THERAPIST/COUNSELOR BEFORE? ____ YES _____NO

(this information is important for the approval process)

Name of provider/Clinic Started seeing/Stopped seeing Frequency Reason

_____

_____

_____

_____

HAVE YOU EVER BEEN ADMITTED TO A PSYCHIATRIC HOSPITAL? _____ YES _____NO

Name of the hospital Dates Admitted and Released Reason

_____

_____

_____

_____

HAVE YOU ATTEMPTED SUICIDE? _____ YES _____NO If yes, please describe: _____

_____

_____

DO YOU ENGAGE IN ANY SELF-HARM BEHAVIORS (LIKE CUTTING)? _____ YES _____NO

If yes, please describe: _____

_____

_____

HAVE YOU EVER BEEN VIOLENT OR AGGRESSIVE? _____ YES _____NO

If yes, please describe: _____

_____

_____

HAVE YOU EVERY USED ANY OF THE FOLLOWING? (MARK ALL THAT APPLY)

_____Tobacco _____Vaping _____Marijuana _____Alcohol

_____Opiates _____Benzos _____Ecstasy _____Methamphetamine

_____Cocaine _____Heroin _____Other:_____

ARE YOU CURRENTLY USING ANY OF THOSE MARKED ABOVE? _____Yes _____No

MEDICATION ALLERGIES _____ NONE _____YES (please explain) _____

_____

OTHER ALLERGIES _____ NONE _____YES (please explain) _____

_____

PLEASE MARK ANY PSYCHIATRIC MEDICATIONS YOU HAVE TAKEN IN THE PAST:

_____Alprazolam (Xanax) _____Diazepam (Valium) _____Mirtazapine (Remeron)

_____Amitriptyline (Elavil) _____Duloxetine (Cymbalta) _____Nortriptyline (Pamelor)

_____Amphetamine (Adderall) _____Escitalopram (Lexapro) _____Olanzapine (Zyprexa)

_____Aripiprazole (Abilify) _____Fluoxetine (Prozac) _____Oxcarbazepine (Trileptal)

_____Asenapine (Saphris) _____Fluphenazine (Prolixin) _____Paliperidone (Invega)

_____Atomoxetine (Strattera) _____Fluvoxamine (Luvox) _____Paroxetine (Paxil)

_____Bupropion (Wellbutrin) _____Guanfacine (Intuniv) _____Quetiapine (Seroquel)

_____Buspirone (BuSpar) _____Haloperidol (Haldol) _____Risperidone (Risperdal)

_____Carbamazepine (Tegretol) _____Iloperidone (Fanapt) _____Sertraline (Zoloft)

_____Citalopram (Celexa) _____Imipramine (Tofranil) _____Topiramate (Topamax)

_____Clomipramine (Anafranil) _____Lamotrigine (Lamictal) _____Trazodone (Desyrel)

_____Clonazepam (Klonopin) _____Levomilnacipran (Fetzima) _____Valproic Acid (Depakote)

_____Clonidine (Kapvay) _____Lisdexamfetamine (Vyvanse) _____Venlafaxine (Effexor)

_____Clozapine (Clozaril) _____Lithium _____Vilazodone (Viibryd) _____Desipramine (Norpramin)

_____Lorazepam (Ativan) _____Vortioxetine (Brintellix) _____Desvenlafaxine (Pristiq)

_____Loxapine (Loxitane) _____Ziprasidone (Geodon) _____Dexmethylphenidate (Focalin)

_____Lurasidone (Latuda) _____ Other: _____

FAMILY MEDICAL HISTORY including great grandparents, grandparents, parents, great aunts, great uncles, aunts, uncles, cousins of any degree, siblings, nieces, nephews, etc.

Have any of your relatives ever had any of the following:

	Yes	No	Relationship to patient
Migraine/Chronic headaches			
Seizures			
Stroke			
High blood pressure			
Heart disease			
Heart attack			
Heart Murmur			
Lung disease			
Asthma			
Gastric reflux disease			
Diabetes			
High cholesterol			
Liver disease			
Kidney disease			
Thyroid disease			
Obesity			
Glaucoma			
Anemia			
Sudden unexplained death			
Dementia			
Cancer			

FAMILY PSYCHIATRIC HISTORY

Have any of your blood relatives ever had any of the following:

	Yes	No	Relationship to patient
Depression			
Bipolar disorder			
Suicide			
Anxiety disorders			
Panic disorder			
Agoraphobia			
Obsessive Compulsive Disorder			
PTSD			
Eating disorder			
Schizophrenia			
Other psychosis			
ADHD/ADD			
Oppositional Defiant Disorder			
Conduct disorder			
Personality disorders			
Tourette's syndrome			
Autism spectrum disorder			
Alcoholism			
Substance abuse			
Psychiatric hospitalizations			

Name_____ **Date**_____

Beck's Depression Inventory

1.
   0 -I do not feel sad.
   1 -I feel sad
   2 -I am sad all the time and I can't snap out of it.
   3 -I am so sad and unhappy that I can't stand it.
2.
   0- I am not particularly discouraged about the future.
   1 -I feel discouraged about the future.
   2- I feel I have nothing to look forward to.
   3 -I feel the future is hopeless and that things cannot improve.
3.
   0 -I do not feel like a failure.
   1- I feel I have failed more than the average person.
   2 -As I look back on my life, all I can see is a lot of failures.
   3 -I feel I am a complete failure as a person.
4.
   0- I get as much satisfaction out of things as I used to.
   1 -I don't enjoy things the way I used to.
   2 -I don't get real satisfaction out of anything anymore.
   3 -I am dissatisfied or bored with everything.
5.
   0 -I don't feel particularly guilty
   1 -I feel guilty a good part of the time.
   2 -I feel quite guilty most of the time.
   3 -I feel guilty all of the time.
6.
   0 -I don't feel I am being punished.
   1 -I feel I may be punished.
   2 -I expect to be punished.
   3 -I feel I am being punished.
7.
   0- I don't feel disappointed in myself.
   1- I am disappointed in myself.
   2 -I am disgusted with myself.
   3 -I hate myself.
8.
   0 -I don't feel I am any worse than anybody else.
   1- I am critical of myself for my weaknesses or mistakes.
   2 -I blame myself all the time for my faults.
   3 -I blame myself for everything bad that happens.

9.

0 -I don't have any thoughts of killing myself.
1 -I have thoughts of killing myself, but I would not carry them out.
2 -I would like to kill myself.
3 -I would kill myself if I had the chance.

10.

0 -I don't cry any more than usual.
1 -I cry more now than I used to.
2 -I cry all the time now.
3 -I used to be able to cry, but now I can't cry even though I want to.

11.

0 -I am no more irritated by things than I ever was.
1 -I am slightly more irritated now than usual.
2 -I am quite annoyed or irritated a good deal of the time.
3 -I feel irritated all the time.

12.

0- I have not lost interest in other people.
1 -I am less interested in other people than I used to be.
2- I have lost most of my interest in other people.
3 -I have lost all of my interest in other people.

13.

0 -I make decisions about as well as I ever could.
1 -I put off making decisions more than I used to.
2 -I have greater difficulty in making decisions more than I used to.
3 -I can't make decisions at all anymore.

14.

0 -I don't feel that I look any worse than I used to.
1 -I am worried that I am looking old or unattractive.
2 -I feel there are permanent changes in my appearance that make me look unattractive
3 -I believe that I look ugly.

15.

0- I can work about as well as before.
1- It takes an extra effort to get started at doing something.
2 -I have to push myself very hard to do anything.
3 -I can't do any work at all.

16.

0 -I can sleep as well as usual.
1- I don't sleep as well as I used to.
2 -I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 -I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 -I don't get more tired than usual.
1 -I get tired more easily than I used to.
2 -I get tired from doing almost anything.
3 -I am too tired to do anything.

18.

0- My appetite is no worse than usual.
1 -My appetite is not as good as it used to be.
2- My appetite is much worse now.
3 -I have no appetite at all anymore.

19.

0 -I haven't lost much weight, if any, lately.
1- I have lost more than five pounds.
2 -I have lost more than ten pounds.
3 -I have lost more than fifteen pounds.

20.

0 -I am no more worried about my health than usual.
1- I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 -I am so worried about my physical problems that I cannot think of anything else.

21.

0 -I have not noticed any recent change in my interest in sex.
1 -I am less interested in sex than I used to be.
2 -I have almost no interest in sex.
3 -I have lost interest in sex completely.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(circle to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

NAME_____ **DATE**_____

TMS Screening Questionnaire

Please read each question carefully, answering accurately and truthfully, and if you have any doubt as to how to answer any question please answer "yes"

	YES	NO
■ Do you have epilepsy or have you ever had a convulsion or a seizure?		
■ Have you ever had a fainting spell? If yes, please describe in which occasion(s)		
■ Have you ever had severe (i.e. followed by loss of consciousness) head trauma?		
■ Do you have any hearing problems or ringing in your ears?		
■ Are you pregnant or is there any chance that you might be?		
■ Do you have metal in the brain skull (except titanium)? (e.g. splinters, fragments, clips, etc.)		
■ Do you have cochlear implants?		
■ Do you have an implanted neurostimulator? (e.g. DBS, epidural/subdural,VNS)		
■ Do you have a cardiac pacemaker of intracardiac lines or metal in your body?		
■ Do you have a medication infusion device?		
■ Did you hold a Heavy Goods Vehicle driving license, pilots license or bus license?		

Affirmative answers to this questionnaire do not represent absolute contraindications to TMS, but the risk/benefit ratio should be carefully balanced by the clinician and patient.

I confirm that I have read and understood the above information and that each question has been answered to the best of my knowledge.

Name_____ **Signature**_____ **Date**_____

IMPORTANT INFORMATION

In order to set up your initial consultation for TMS the following pieces of information are required along with this complete packet:

1. A referral for TMS from your current PCP or Psychiatrist (if you have one).
2. Past clinical visit history from PCP or Psychiatrist.
3. Front and back copy of insurance card.

* The information from previous doctors is welcomed to be faxed to us- fax: 479-684-3941 *

The more information provided to us in these areas the easier and quicker the approval process will be. If you have any questions you can call our clinic new patient line.

Thank you, we look forward to working with you.
NWA Psychiatry

Signature of person completing form Date

AUTHORIZATION TO RELEASE PRESCRIPTION HISTORY

Patient Name_____Date of Birth_____

Telephone_____Email Address_____

Home Address_____

City_____State_____Zip_____

I request and authorize the release of my prescription history from:

Pharmacy_____

City_____State_____Zip_____

☐ last 2 years ☐ last year Phone_____Fax_____

Release my records to:

Northwest Arkansas Psychiatry, a MANA Clinic
4700 S. Thompson Suite C-103
Springdale, AR 72764
Phone: (479)571-6363
Fax: (479)684-3941

By singing below I understand that:
I may revoke this authorization at any time. In signing this form, I am authorizing the release of my protected health information. I understand that upon my release this health information is no longer protected and has the potential to be re-disclosed by the recipient. Treatment will not be denied to me if I do not sign this form. The authorization expires one year from the date of this signature.

Signature_____Date_____